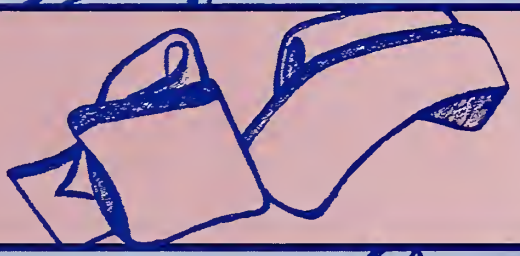
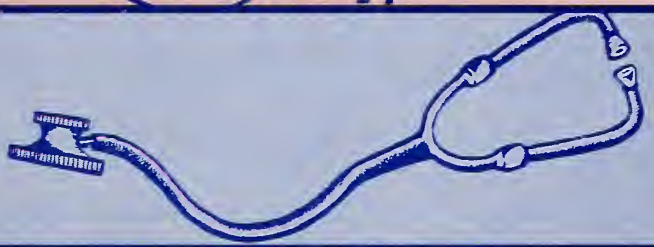
AMPHLET

CONSUMER FRAUD

HOW TO HELP STOP MEDICARE FROM BEING RIPPED-OFF





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I'm Bill the Pelican and I'm here to tell you about how to spot people who steal from Medicare and what you can do to stop the thieves.

Every year fraud costs Medicare $$$ and you pay part of those costs. You pay higher taxes and more in coinsurance and deductibles to cover these Medicare losses.

Most providers of health care are honest business men and women who want to meet your health care needs. They understand that programs like Medicare rely on their honesty and good judgment. Medicare providers include: hospitals, nursing homes, home health agencies, laboratories, end stage renal disease facilities, suppliers of home medical equipment, physicians, physical therapists - just to name a few.

When you receive items or services from these providers, they will bill Medicare for you. This "bill" is called a claim and it is sent for payment to one of the insurance companies that processes claims for Medicare.

A relatively small group of providers take advantage of you and the Medicare program. They often pretend to be helping you, but in fact, they're only helping themselves to Medicare money.

We have to work together to stop fraud.

You can also read about home medical equipment fraud. Call your Medicare carrier for a copy of my pamphlet called, "Consumer Fraud, Medicare and Home Medical Equipment."

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CHAPTER 1

Medicare Fraud Is a Federal Crime!

In 1992, almost 800 million claims for Medicare benefits were submitted to Medicare for payment. Some of these claims were fraudulent. As fraudulent claims were detected, some providers were warned; some were fined; some were thrown out of the program; some were sent to prison. Despite our efforts, it is estimated that as much as $10 billion was stolen from Medicare.

"When people steal from Medicare they steal from every one of us."

What is fraud? Fraud happens when someone knowingly and willfully lies in order to get paid. Fraud usually involves careful planning. It happens when a provider misrepresents on the claim form what was furnished. In other words, it's cheating.

We need your help to catch more of the cheaters. As the consumer, you can tell us whether you got the item or service as billed.

CHAPTER 2

Who Pays?

You pay! Costs to Medicare are used to figure the annual deductible and the amount of your monthly premium. Fraud causes these amounts to be higher than they need to be. Therefore, you pay more "out-of-your-pocket."

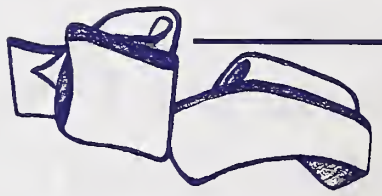
After you pay your monthly premium and the annual deductible, you still owe a share of the Medicare-approved amount for most supplies and services. This share is called coinsurance. Usually, your coinsurance share is 20 percent of the Medicare-approved amount.

If you receive an item or service that's not medically necessary, you or your private insurance company pay at least 20 percent of the cost of that item or service. Remember, private insurance premiums, like Medicare's, are based on the costs to these companies. The higher the costs, the higher the premiums.

So, as you can see, Medicare fraud causes you to pay more in insurance premiums, coinsurance and deductibles. We need to work together to stop fraud. Stopping the cheaters can save you money.

CHAPTER 3

Many Offices Must Work Together to Fight Fraud



The Health Care Financing Administration (HCFA) is the federal agency that runs the Medicare program. HCFA uses health insurance companies, such as Blue Cross and Blue Shield, The Travelers, and AEtna, to process bills for Medicare-covered items and services. Although these companies have their private business, the part of the company that processes Medicare claims is a separate operation.

The Medicare operations part of these companies ensures that the claims are paid correctly. These companies want to know about people who bill incorrectly or who furnish unreasonable or unnecessary services. The companies have Medicare fraud units whose job it is to catch people who steal from Medicare.

The Office of Inspector General (OIG), of the Department of Health and Human Services, is the law enforcement agency that investigates and prosecutes people who steal from Medicare. The OIG works closely with Medicare insurance companies, as well as with the FBI, Postal Inspection Service and other federal law enforcement agencies.

CHAPTER 4

What You Can Do

When you suspect that Medicare has improperly paid a claim , contact the insurance company that paid. The company will contact the provider to investigate. If you wish, your name will not be used. If you feel comfortable doing so, you may contact the provider that submitted the claim before calling Medicare. Inform the provider that Medicare paid for the item or service. Explain why you believe Medicare should not have paid.

If the provider made an honest mistake, it can be corrected and Medicare will get a refund. If the provider told you before you received the service that Medicare is not likely to pay for the service, you may have to pay for the service.

How do you know when Medicare has paid a claim on your behalf? Medicare will send you a form called an Explanation of Your Part B Medicare Benefits (EOMB). This notice explains what was billed; what Medicare paid; and what you owe. The EOMB also contains the name, address and telephone number of the Medicare claims processing company. Some have special "Fraud" hotlines which put you directly in touch with the fraud unit.

CHAPTER 5

The Most Common Rip-offs

- Billing for medically unnecessary items or services. Under Medicare, these are items or services that are not medically necessary to improve your condition. Medicare does not pay for items or services unless they are determined to be medically necessary, reasonable, and appropriate for treating your medical condition. Services that exceed your needs are not considered medically necessary. Medicare does not generally pay for preventive medicine, although there are a few exceptions.

- Lying to Medicare about your condition to get Medicare to pay for services.

- Performing services that exceed what is needed. Excessive diagnostic x-rays, clinical laboratory, consultative services, and unneeded home medical equipment are examples.

- Offering or accepting referral fees from another provider in exchange for referring you to them. These "fees" are considered "kickbacks."

- Billing for ambulance services that Medicare does not cover. Medicare never pays for transportation from your home to a physician's office or to a dialysis center that is not at a hospital. If you, or a member of your family, have been transported by ambulance to a doctor's office for routine dialysis, and Medicare paid for the trip, it is possible that the reason for the trip was misrepresented on the claim. Report such billings.

"When all is said and done, you pay higher premiums when people steal from Medicare. Each time Medicare pays a claim it shouldn't, the government is being ripped-off, and as a taxpayer so are you."

- Misrepresenting items and services on the claim form. The provider bills for an item or service which wasn't furnished or which differs from the service provided. For example, a physician bills for an initial visit but the visit was a follow-up. A podiatrist bills for foot surgery but only trimmed the toenails. A laboratory charges for blood tests, but no tests were done. A supplier delivers a basic wheelchair but actually bills for a more expensive model.

There are other violations that are not fraud, but which cost you nonetheless. For example, if your provider charges you for filing your Medicare claim, he or she is breaking the law. You should report it.

If you are billed for the 20 percent co-payment, although it was already paid by your private insurance company (often referred to as a supplemental insurer), you are being ripped off. If your private insurer pays after you paid the provider, request a refund from the provider.

CHAPTER 6

When Should You Suspect a Rip-off?

Although most providers and suppliers are sincerely interested in your health, some are more interested in feathering their own nests. The following are practices you should look out for since they may indicate that you and Medicare are about to be ripped-off.

- Providers who advertise free testing or screening in exchange for your Medicare number. These providers may plan on billing Medicare without your knowledge. If the screening is truly "free," they do not

need your Medicare number. ***Never give out your Medicare number to people you don't know.*** Treat your Medicare card like you would a credit card.

- Providers who present themselves as being a part of Medicare, the Health Care Financing Administration, the Department of Health and Human Services, the Social Security Administration or any other branch of the federal government. ***Neither the federal government nor Medicare endorses the products or services of any individual provider.*** Be suspicious of such providers. It's OK for providers to say that they "participate" or are "certified" by Medicare to furnish services – if true.

- Any offer of free medical equipment. Many times the bills will contain false statements designed to get Medicare to pay. ***Only your physician can order medical equipment for you.***

- Any provider of health care items or services who tells you that the item or service is not usually covered, but they know how to bill Medicare to get it paid. This provider may be telling you that he or she knows how to cheat Medicare. ***Don't agree to let them do it.***

- A provider who uses pressure or scare tactics to sell you high priced medical services or diagnostic tests without giving you the opportunity for a second opinion. ***Unless it is an emergency, there is always time for a second opinion.***

- A provider who says that he or she will not require you to pay the 20 percent co-payments or deductibles without first investigating your ability to pay. For example, "It's the doctor's policy not to charge the Medicare co-payment." Such offers may be offered as an incentive to get you to accept items or services you don't need, or to influence your choice of a medical provider. ***Routine waiver of co-payments and deductibles is illegal.***

These are just some of the situations that may end up as fraudulent claims. There are many others. You need to be careful. Many times it is the patient who is stuck with thousands of dollars in health care bills for unneeded services.

In many cases, you will not suspect foul play until you review the Explanation of Your Part B Medicare Benefits. These explanations include information on whether or not Medicare paid, how much, and the item/service for which Medicare paid. These statements are valuable in detecting Medicare fraud. Look for:

- Duplicate payment for the same service;
- Ambulance services you are not aware of;
- Payments for home medical equipment while you or a family member are in a Medicare approved hospital or nursing home;
- Dates of service on the EOMB that differ from the dates you actually received the service;
- Outpatient services billed while the patient was in the hospital; and
- Items or services you do not recall getting. Remember, however, that there are some instances when you will receive bills from a provider you never saw. For example, you may have gotten services from radiologists or cardiologists who interpret test results for your personal physician. You may never meet these consultants, but they perform real, necessary services.

CHAPTER 7

How to Report Fraud

If you believe Medicare is being cheated, call or write the Medicare company that paid the claim. The name, address and telephone number are on the Explanation of Your Part B Medicare Benefits.

You do not have to give your name when you file a complaint. However, if you want to be informed of the results of the investigation, you will have to give your name, address and Medicare number.

Before contacting the Medicare claims processing company, carefully review the facts as you know them and as shown on the Explanation of Your Part B Medicare Benefits. Write down the:

1. Provider's name and any identifying number next to or below his or her name;

2. Item or service you are questioning;

3. Date on which the service is shown to have been furnished;

4. Amount approved and paid by Medicare;

5. Date of the explanation of Medicare benefits;

6. Name and Medicare number of the person who supposedly received the item or service; and

7. Reason you believe Medicare should not have paid.

If you plan to write rather than call, clearly state at the beginning of your letter that you are filing a fraud complaint. This will ensure that your complaint is processed through the mail room to the fraud unit. Address the envelope to the name and address on the explanation of Medicare benefits, attention: *Medicare Fraud Unit.*

"Help me stamp out Medicare fraud by reporting fraudulent activity to the proper office."

What You Should Expect from Your Medicare Carrier or Fiscal Intermediary When You File a Complaint with Medicare Alleging Fraud or Abuse

The receipt of your complaint will be acknowledged within 30 days. The fraud unit will give you a date by which they expect to complete their investigation of your complaint. If their investigation is not completed by the date promised, they'll notify you of their progress and expected completion date.

The fraud unit investigator will reach one of three conclusions and will notify you of his or her decision:

1. Although the claim may have appeared to be wrong, the provider correctly filed the claim. This is often the case with services billed by consultants and providers of diagnostic services such as clinical laboratories, radiologists, etc.

2. The provider made a billing error which appears to have been an honest mistake.

"Medicare wants to know. File a complaint if you believe Medicare is getting ripped-off."

3. The provider appears to have filed a false claim.

If the amount at issue is relatively small and there doesn't appear to be a pattern of fraudulent claims, Medicare will recover the overpayment and issue a warning to the provider.

If, however, the review discloses a pattern of fraud, the case will be referred to the Office of Inspector General for civil, criminal, and/or administrative action.

If you are told that the matter is being referred to the Office of Inspector General, the fraud unit is telling you that it agrees that fraud may exist and they are referring it for further criminal investigation.

"White collar" crime investigations often take a long time. Because of the complexity of these cases, the investigations may take many months, even years, to bring the wrong-doer to trial. Also, in certain instances involving very sensitive matters, it may not be possible to give out information during the course of the investigation.

CHAPTER 9

Penalties for Ripping-off Medicare

When a case is referred to the Office of Inspector General for investigation, the Office of Inspector General coordinates its investigation with several other federal and State law enforcement agencies.

Depending on the merits of the case, one or more of the following penalties may apply:

- Criminal Prosecution – It's a felony to steal from Medicare and some providers are sent to prison. People convicted are usually required to pay back what they stole, plus additional money in fines. People convicted are also barred from doing business with Medicare and Medicaid for a minimum of 5 years.

- Civil Proceeding – The U.S. Attorney may decide to file a civil suit or may decide that the interests of the program are best served by settling the case. In these cases, the amount stolen plus additional money is paid to the government in the form of penalties and fines. The penalties may include not being permitted to bill Medicare and Medicaid for a number of years.

- Administrative – Even when the U.S. Attorney's Office declines to prosecute the case, the Office of Inspector General may take action to exclude the provider. This means that for a certain number of years Medicare and Medicaid will not honor bills from the provider. If your doctor is excluded from Medicare, contact your Medicare carrier for the name of the closest participating physician that can meet your medical needs.

In addition to the penalties the Office of Inspector General and the U.S. Attorney's Office may impose, there are other administrative penalties available to Medicare, such as termination of their participation agreements.

Some providers, such as hospitals, nursing homes and home health agencies and some suppliers, such as clinical laboratories, end stage renal disease facilities and ambulatory surgery centers, must be approved by Medicare before they legally can be paid for Medicare-covered services.

If these providers and suppliers furnish bad or medically unnecessary care, physically or verbally abuse patients, or otherwise violate federal health and safety requirements, they may lose their approval to bill for Medicare and Medicaid services. Action to take away Medicare approval for these providers and suppliers is sometimes initiated by the Medicare Survey and Certification Agency, usually part of the State's Department of Health.

As the consumer, you are often in the best position to tell Medicare if you believe you are being ripped off. Medicare needs your help. They can't do it alone. It's your responsibility.

The people in HCFA, the Office of Inspector General, State agencies and law enforcement agencies across the United States are committed to stopping Medicare fraud and, indeed, all health care fraud and abuse.

If you would like someone from Medicare to talk to your group about Medicare fraud and what you can do to help stop it, contact the Medicare Fraud and Abuse Information Coordinator at your local Medicare insurance company. The company's name and telephone number are on the Explanation of Your Part B Medicare Benefits.

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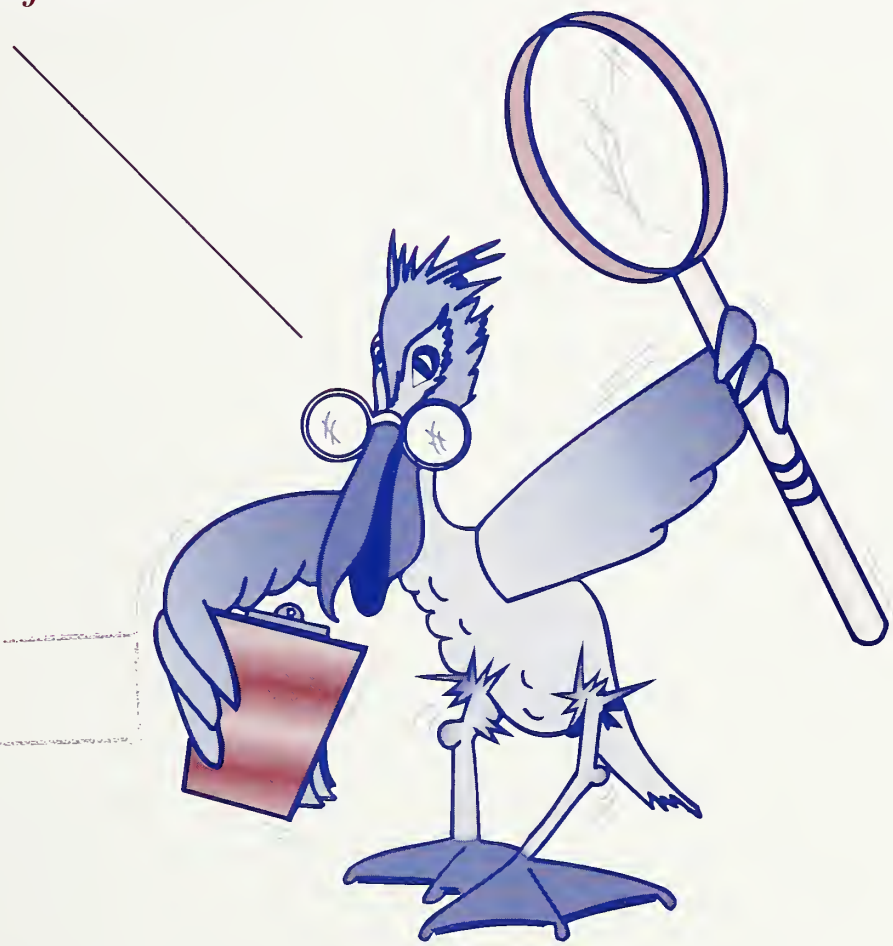
"Remember, people who steal from Medicare are stealing from you. Let's work together to stop Medicare fraud and abuse. There are Medicare fraud units across the United States who will investigate your complaints. Let them know when you discover what appears to be fraud."



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